DOCUMENT RESUME

ED 037 675 AC 006 733

AUTHOR Londoner, Carroll
TITLE A Diagnostic Procedural Model for Identifying Real Educational Needs.
PUB DATE 67
NOTE 18p.

EDRS PRICE EDRS Price MF-$0.25 HC-$1.00
DESCRIPTORS Administration, *Administrative Personnel, *Educational Needs, Environmental Influences, Evaluation, *Group Dynamics, *Hospital Personnel, Management Development, Measurement Instruments, Observation, Participation, Questionnaires, Rating Scales
IDENTIFIERS Bales Interaction Analysis Sheet

ABSTRACT

This study evaluated educational problems and needs in the administrative management council of Bloomington Hospital, Bloomington, Indiana, in order to help produce a more effective task group within the hospital's institutional framework. Over a seven week period, the investigator observed department heads in their weekly conferences by means of the Bales Interaction Analysis Sheet (verbal participation) and a specially developed process report form for evaluating group structure and processes. The history of the development of this group, indicating various lines of confusion, led the department heads during the collaborative diagnosis to suggest several educational needs. Accordingly, the investigator, as the diagnostician, recommended the setting of an overall hospital philosophy with principles and guidelines for future work; a clarified organizational structure indicating proper lines of authority and responsibility; and some form of participation training in procedures for decision making and problem solving. (A questionnaire and the diagnostic instruments are included.) (LY)

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

ED037675

A DIAGNOSTIC PROCEDURAL MODEL FOR IDENTIFYING REAL EDUCATIONAL NEEDS

by

Carroll Londoner

AC006733

A DIAGNOSTIC PROCEDURAL MODEL FOR IDENTIFYING REAL EDUCATIONAL NEEDS

by

Carroll Londoner

The purpose of this study was to identify the real educational needs of the Line Department Head group at the Bloomington Hospital in Bloomington, Indiana. This group is composed of the eight departmental heads of the hospital who meet weekly on Wednesday afternoons immediately after lunch in the Hospital conference room. In addition the hospital administrator and his secretary attended every meeting.

In order to help this group of hospital workers become a more efficient work group within the institutional framework of the hospital three particular questions were raised:

1. What are the overall 'symptoms' (being interpreted to mean "apparent difficulties") of this group as they work together?

2. What are the underlying problems apparently causing these symptoms?

3. What are the real educational needs of this group deemed necessary for making it a more efficient and cohesive working unit?

The study covered a seven week period, six of which the diagnostician was present with the group either as an observer or as a group member. One week he was absent from the group. This was the fourth meeting after the diagnostic study had begun.

Three kinds of data were collected. The first kind was based on three weeks of personal observations by the diagnostician

using two instruments of observation. The first was the Bales Interaction Analysis Sheet which is designed for tabulating the verbal participation of the participants into two basic categories, each of which is sub-divided into two sub-parts. The first major division of the Interaction Analysis Sheet is for tabulating the "Social-emotional Responses" of the group members. These responses may be classified into either positive or negative reactions to the group and its particular problems. The second major division is for tabulating the "Task-Oriented Responses" of the group members. These responses may be classified as remarks aimed at helping to move the group forward in its problem-solving activities. One sub-category tabulates responses in terms of persons who try to move the group forward by asking for "orientation," "opinions from others," or "suggestions from others." The second sub-category tabulates responses of persons trying to move the group forward by attempting to answer the persons who have asked for 'opinions,' 'orientations,' or 'suggestions.' The Bales Interaction Analysis instrument was used for a period of forty-five minutes at each meeting in order to obtain a relatively objective pattern of verbal responses. The diagnostician did not sit with the group but seated himself in a corner of the room where he could observe the processes of the group at work.

The second instrument of observation was a Process Report Form developed by the diagnostician purposefully for this particular study. Later in the paper a discussion will indicate in what manner this instrument was fashioned. A copy of this instrument

is appended. This Process Report Form was used during the second half of the meeting. A scale was devised on a six-point continuum such that 'zero' was the mid-point of the scale. To the left of the zero the scale rose in magnitude away from the zero so that the last number farthest away from zero was the number 3. To the right of the zero the scale rose in magnitude away from zero such that the last number farthest away on the right side was the number 3. Thus the scale looked like this:

3 2 1 0 1 2 3

The numbers on the left side of the scale indicated that the group needed more help in a given area. The numbers on the right side indicated that the group needed less help in the same area. One check mark was placed along the continuum for each item in the Process Reprot Form. The use of this form represented the diagnostician's subjective interpretation of each item on the form. It was used primarily to complement the somewhat more objective Bales Interaction Analysis Sheet. Nevertheless, the Process Report Form indicated from week to week definite patterns cnncerning group structure and processes.

The second kind of data gathered was by personal interview. Each of the departmental heads, save one, was interviewed approximately forty-five minutes in the conference room. It was found that the conference room was most conducive for a quiet interview. The lone interviewee was not available on the 'interview day.' When he was available it was deemed necessary to make the interview in his office. Prior thought cnnfirmed the suspicion that

holding interviews in a person's office might not give a continuous uninterrupted discussion. This was the case since the interview was interrupted at least three times by phone calls.

The interview schedule was of the open-ended type and consisted of six questions designed to be supportive of the observational data gathered with the other instruments. The interviewee was given a copy of the questions and was asked to take several minutes to read them over. Then the diagnostician went over each of the questions attempting to clarify any ambiguity inherent in the schedule. After discussing all six questions in turn, they returned to the first question. The diagnostician wrote down the essential answers the interviewee gave to each question. Before leaving each question, the diagnostician made sure to read back to the interviewee what he had said under each question. He prefaced his remarks with "is this what you said?" or words to that effect. This was done so the interviewee was aware that his essential thoughts and meanings were correctly recorded. Only the diagnostician saw the completed interview schedules and used that data to support the data obtained from the observations.

The third kind of data was based on the collaborative diagnostic procedure between the corporate group and the diagnostician. This took place over a two week period when he moved from the observer role into functioning with the group as one of its members. His role at this time was primarily that of a resource person and catalyst to get the group started into thinking about the symptom-problem-need diagnostic procedure.

Data were recorded on newsprint that was suspended from the walls so that the group members could see the developments and conclusions of their discussion. The collaborative part of the diagnosis took place for two consecutive weeks for approximately two hours in length.

In this study the diagnostician followed the following procedural steps:

1. Selected the level of diagnosis. In this case the group was the particular level being diagnosed.

2. Selected 'categories," i.e., areas in which there is likely to be a "Problem!' This is predicated upon previously established adult educational research into the processes of groups.

   These 'categories' numbered 7 and consisted of the following possible "problem areas:"
   a. Goal Orientation and Direction
   b. Leadership and Control
   c. Psycho-social atmosphere
   d. Physical set-up
   e. Mechanics of Meeting
   f. Skills of Group Members
   g. Problem-solving Skills

   Additional room was left for special comments on factors helping or disturbing the group.

Under each of these 'categories' 'possible' Criteria of Adequacy were selected. Criteria of Adequacy was interpreted to mean:

a. Conditions considered by the educator as 'satisfactory' 'appropriate,' or 'ideals' to head for.

b. A standard of value or norms found acceptable to the diagnostician for observational purposes.

The selection of these categories and criteria of adequacies formed the "Process Report Form" which was used as an observational tool. (cf. pages 2 and 3).

3. Identified "symptoms" of problems. Symptoms was interpreted to mean 'apparent difficulties' the group might be having in working together.

   The diagnostician perused the data gathered from the various diagnostic instruments and attempted to form these symptoms into "patterns or clusters of difficulties" called 'syndromes.' It was assumed that these syndromes (clusters of symptoms) would be related somehow to the underlying problems the group was encountering.

   At this point (beginning of 5th meeting) the diagnostician moved from the observer role into a collaborative role with the group, and asked them to join him in step number 3, that is, in identifying symptoms, then syndromes.

4. Identified Real Educational Needs. Real educational Needs was interpreted to mean 'lacking' but required concrete "understandings,""attitudes," and "skills" obtainable through adult education means. The educational needs were prescribed or projected on the basis of the identified problems. This was a joint "collaborative" task between the group and diagnostician.
   The needs were basically thought of in terms of "internal human needs" (feelings, attitudes, skills lacking but required to obtain a more desirable condition) and "external"or "instrumental" needs ('situational' needs which may be overcome by adult education learning situations).

It would be helpful here to elaborate on step number three above indicating the way the symptoms and syndromes of problems were arrived at. The diagnostician prepared several large charts to be placed in the conference room. These were printed on newsprint. One chart reviewed the basic steps in the Diagnosis of the group. The diagnostician indicated to the group that he had undertaken the first two steps himself, and in part had given some consideration to the symptoms as garnered from the data. It was at this point that he attempted collaborative diagnosis by asking the group to take an active role in identifying some

of the symptoms they themselves had observed. It is interesting to note that the personal contact between group members and the diagnostician in the interviewing process had two effects: 1) It seemingly broke down any apparent barriers which might have existed between the diagnostician and the group member. Thus, good rapport had been established. Moreover, this rapport had been reinforced by occasional chats over coffee in the employee's dining room or by chance meetings of the halls. 2) The questions on the interview schedule apparently provoked some conscious reflective thinking in the various group members such that they were able to easily identify some of the obvious symptoms within the group. These symptoms were printed upon another chart entitled: "Step III of the Diagnosis: Relate the Patterns of Difficulties (syndromes) to several Problems causing the group these difficulties.

In order to expedite the diagnostic procedure (the group had willingly devoted almost all of its work time to discussing these matters in both meetings) the diagnostician suggested (over the two week period) eleven 'symptoms' he had gleaned from the observation instruments and the personal interviews. Below are the eleven symptoms:

1. Bringing up 'minor' problems of various departments, seemingly unrelated to the larger group's concerns.

2. Getting away from the major issues of the hospital (expressed 'ideally' as "better patient care" by all department heads.

3. The main purposes or goals of the group seem fuzzy and unclear which seems to parallel a 'fuzziness' in the overall goals and structure of the hospital itself.

4. The organizational structure of the hospital and hence the group appears to be 'fuzzy.' There is apparent confusinn concerning who has what authority and what responsibilities.

5. Authority and responsibility for various tasks in hospital seem unclear.

6. Verbal participation shared mainly by a few persons in the group.

7. Some days there seem to be more laughing and an air of easiness than other days.

8. Little building upon other person's contributions or helping them take active part in the discussion.

9. Great percentage of verbal responses on Bales Interaction Analysis sheet are of the 'information' and 'opinion' giving. Little asking for direction orientation.

10. Often much difficulty in problem-solving. In apparent frustration, tendency was to want the leader (hospital administrator) to "come up with the answers and make final decisions."

11. Little knowledge of the background of the individuals in the group or their likes and/or dislikes.

Over the two week period the group came to the following patterns of difficulties (syndromes) and listed them on the chart.

1. Lack of hospital (hence Personnel) Philosophy.

2. Lack of direction of whole hospital and this particular group due to lack of hospital philsophy.

3. "Policy" and "operational/procedural" clarification of group's goals and purposes within the framework of the hospital is lacking.

4. Confusion of lines of authority and responsibility both in vertical and horizontal directions within organizatinnal framework.

5. Lack of methodological approach to discussion and solving of problems efficiently.

After having identified the syndromes of problems the group felt that their major 'problem' was a lack of a comprehensive hospital philsophy thereby causing a lack of direction for this particular group. A partial explanation of this lack of direction may rest in the historical development of this group.

A number of years ago, when the hospital was a much smaller unit, a group of persons holding tentative authority and responsibilities in the hospital were called to gether by the hospital administrator of that time. The purpose of this meeting was to develop and write up a 'safety plan' for the general welfare of the hospital. As such, this was a task-oriented group and were summarily disbanded upon completion of this task. The next administrator approximately five to seven years ago reformed this 'line head' group. Apparently the administrator felt a need to develop 'strong' departmental heads able to aid him in his various duties. This group became a learning group in order to become a "management training" group in order to develop a proper understanding of their roles and responsibilities as departmental heads. They underwent approximately ten months of 'management training' in which various techniques such as role playing was used to augment the learning situation. Apparently after that period the learning-training sessions were deemed "not successful" and were abandoned. Apparently weekly meetings were abandoned for sometime. Occasionally 'called meetings' were instigated for solving particular problems.

Later the group was re-established. However, the group

this time seemed to be composed of persons who were deemed congenial to work with. That is, persons chosen to work in this group did not necessarily follow the organizational flow chart of the hospital. Instead, they seemed to be persons, having some lines of authority, but not necessarily departmental heads, who could work well together in helping the administrator with some of the problems at hand. Apparently, some antagonism developed between some of the persons, perhaps as a hold-over from the previous training-group sessions. Interviews with persons who composed this group indicate that the meetings turned into basically "gripe sessions" but little"real"problem-solving was accomplished. Over a period of time some of the persons composing this group terminated work at the hospital. New persons hired in their places automatically assumed the role of their predecessor within this group structure. Apparently they were not told why they were chosen for this group. Thus, where the prior group had been chosen according to 'nice personalities to work with' (even though they did not have direct lines of authority or responsibility according to the hospital organizational chart), these people automatically inherited the precedent tasks of the group.

Gradually, there was nearly a complete turn-over in personnel composing this group. At the present time most of the members are new to the hospital and to the group. Many admit to confusion as to "why" they are on the group. Being confused as to 'why' has led to confusion of the nature and purpose

of this particular group within the institutional framework of the hospital. As such, kinds of problems to be brought before this group are not really known. There tends to be basic confusion as to how much responsibility, apart from the group, should a departmental head have in attempting to solve problems in his particular department. Moreover, not knowing how much responsibility one has on his own, the members often bring minor problems to the group to be solved. Hence, much time is spent in "maintenence type of problems" of the hospital, or as one group member expressed it, with "band-aid" type problems to meet immediate emergencies. Little or no long-range planning for the hospital's future is able to be brought before the group for their consideration.

The history of the development of this group, indicating various lines of confusion, led the group during the collaborative diagnosis to suggest the following educational needs. These, they felt, were crucial for the efficient working of this group. On a chart entitled "Step IV of the Diagnosis: Identify some of the Educational Needs of the group," the following needs were identified:

1. Set out an overall hospital philosophy as principles and guidelines for future work.
2. To clarify the organizational structure of the hospital (re-design the flow chart, thus indicating lines of authority and responsibility). This in turn would:
    A. Clarify the group's structure and the individual's authority and responsibility.
    B. Clarify the Board's and this group's role in policy making and policy development activities.

3. To engage in some form of participation training so group may learn efficient decision-making and problem-solving procedures.

It is unquestionably true that if the group had had more time, perhaps several more weeks, to work together in the collaborative diagnosis they would have identified more problems and their educational needs. However, it seemed apparent to all present that the symptoms, And syndromes did identify these immediate problems which in turn dictated these educational needs of this group.

An oral evaluation on the effectiveness of this particular diagnostic procedure took place. The diagnostician asked the group for their candid feelings about this procedure which had the diagnostician operating for several weeks as an observer and then moving into the collaborative diagnostic role as opposed to the procedure of moving immediately into a collaborative diagnosis. The group feeling seemed to be that this was an effective procedure for this particular group. It allowed an opportunity for the group members to develop some rapport with the diagnostician before he moved into his collaborative role. None said they had felt uncomfortable with his presence as an observer, particularly since he had been introduced by the hospital administrator as a student at the university working on a class project in learning more about the way groups work together. One member of the group indicated he had held some suspicion that perhaps there was something more to the diagnostician's presence than met the eye, particularly since "universities are always doing some kind of study or other and don't tell you what it is."

Most agreed that they had no idea of how a diagnostic procedure that immediately began with collaborative diagnosis would have worked since none had ever been involved in this type of process before. The general group concensus seemed to be that this procedure had been most effective in stimulating them toward recognizing that they actually had 'problems' which they didn't believe existed before this time.

RECOMMENDATIONS

On the basis of the identified educational needs of this group, the diagnostician recommends the following:

1. Some form of participation training for the group members, either in a week-end conference experience or in a concentrated period such as is experienced in the Adult Education Institutes at Indiana University.

   A. Immediate participation training for the hospital administrator to help him gain additional insights for carrying on the diagnosis already begun with this group.

   B. A participation training institue held at the hospital for the members of this group, possibly by an Adult Education intern from the Bureau of Studies in Adult Education from Indiana University.

2. A clarification of the hospital's organizational structure indicating proper lines of authority and responsibility.

3. The development of an overall hospital philsophy as principles and guides which may be translated into concrete policies and operational procedures to be communicated to the rest of the hospital employees.

In conclusion, it is interesting to note that this diagnostic study has supported one of the basic assumptions about diagnosis in adult education: A symptom at one level (the group) may be a problem at another level (the institutionl level of the whole hospital).

IR SHEET

NAMES AND NUMBERS (put in full name and seat no. of each person)

Categories													Totals
1 Shows solidarity, raises other's status, gives help, reward													
2 Shows tension release, jokes, laughs, shows satisfaction													
3 Agrees, shows passive acceptance, understands, concurs, complies													
4 Gives suggestion, direction, implying autonomy for other													
5 Gives opinion, evaluation, analysis, expresses feeling, wish													
6 Gives orientation, information, repeats, clarifies, confirms													
7 Asks for orientation, information, repetition, confirmation													
8 Asks for opinion, evaluation, analysis, expression of feeling													
9 Asks for suggestion, direction, possible ways of action													
10 Disagrees, shows passive rejection, formality, withholds help													
11 Shows tension, asks for help, withdraws out of field													
12 Shows antagonism, deflates other's status, defends or asserts self													
TOTALS													

IR_____ Time of day_____

Grp number_____ Date _____

No in group_____

Topic _____

_____

PROCESS REPORT FORM

Group_____ Name of PR_____ Date_____

Goal Orientation and direction

1. Goals made explicit	3	2	1	0	1	2	3
2. Interest and involvement in goals	3	2	1	0	1	2	3
3. Off-goal wandering	3	2	1	0	1	2	3
4. Subordination of individual goals to group goal	3	2	1	0	1	2	3

Leadership and control

1. Centralized leadership	3	2	1	0	1	2	3
2. Distributed (functional) leadership	3	2	1	0	1	2	3
3. Decision-making by designated leader only	3	2	1	0	1	2	3
4. Decision-making by whole group	3	2	1	0	1	2	3
5. Attentive to group needs	3	2	1	0	1	2	3
6. Encouraged participation	3	2	1	0	1	2	3
7. Gave direction to group thinking	3	2	1	0	1	2	3
8. Kept channels of communications open	3	2	1	0	1	2	3
9. Summarized and verbalized agreements	3	2	1	0	1	2	3
10. Helped resolve conflict	3	2	1	0	1	2	3
11. Stimulated creative thinking	3	2	1	0	1	2	3
12. Encouraged criticism	3	2	1	0	1	2	3
13. Balanced abstract thought with concrete suggestions	3	2	1	0	1	2	3
14. Regulated participation of members	3	2	1	0	1	2	3
15. Power and status structure evident	3	2	1	0	1	2	3

Psycho-social atmosphere

1. Warmth and friendliness on 'surface'	3	2	1	0	1	2	3
2. Warmth and friendliness in 'depth'	3	2	1	0	1	2	3
3. Permissiveness and spontaneity	3	2	1	0	1	2	3
4. Inhibited and rigid	3	2	1	0	1	2	3
5. Threat and/or hostility	3	2	1	0	1	2	3
6. Supportative and encouraging	3	2	1	0	1	2	3
7. Competitive	3	2	1	0	1	2	3
8. Cooperative	3	2	1	0	1	2	3

Physical set-up

1. Awareness of temperature and ventilation	3	2	1	0	1	2	3
2. Chair and table arrangements suitable for eye to eye contact without strain	3	2	1	0	1	2	3
3. Room the proper size for the group	3	2	1	0	1	2	3
4. Seats arranged to avoid glare from windows	3	2	1	0	1	2	3
5. Visual aid material present or adequate for the particular meeting _____	3	2	1	0	1	2	3
6. Paper and pencils provided for members	3	2	1	0	1	2	3
7. Members can see blackboard, easels, posters, charts without strain	3	2	1	0	1	2	3

E. Mechanics of Meeting

1. Use of agenda or brief outline	3	2	1	0	1	2	3
2. Use of formal reports	3	2	1	0	1	2	3
3 Use of process reporting with observer	3	2	1	0	1	2	3
4. Use of sub-grouping for problem-solving	3	2	1	0	1	2	3
5. Method of decision-making: Voting	3	2	1	0	1	2	3
6. Method of decision-making: Concensus	3	2	1	0	1	2	3
7. Some method of evaluation used	3	2	1	0	1	2	3
8. Evidence of pre-planning	3	2	1	0	1	2	3

F. Skills of Group Members

1. Overall possession of communication skills	3	2	1	0	1	2	3
2. Understanding and use of discussion technique	3	2	1	0	1	2	3
3. Understanding and use of other techniques	3	2	1	0	1	2	3
4. Ratio of verbal participation spread equally among members	3	2	1	0	1	2	3
5. Adaptable and flexible in various roles	3	2	1	0	1	2	3
6. Listener-follower behavior adequate	3	2	1	0	1	2	3
7. Gives attention to all members of group	3	2	1	0	1	2	3
8. Willingness to build on others contributions	3	2	1	0	1	2	3

G. Problem-Solving skills

1. Ability of members to see point at issue	3	2	1	0	1	2	3
2. Abilities to restate,clarify, summarize	3	2	1	0	1	2	3
3. Idea productivity and creativity (solutions, ideas, suggestions flow freely)	3	2	1	0	1	2	3
4. Ability to keep on topic and not wander to ---unrelated topics	3	2	1	0	1	2	3

H. Special comments on factors helping or disturbing the group:

INTERVIEW SCHEDULE

1. About how many people would you say you know "well" in the group?

2. What do you feel are the main purposes for the existence of this particular group in the hospital?

3. What are some of the things you feel the group should be doing that it is not presently doing?

4. What one thing would you like to see the group doing in the future?

5. What are some of the ways you make a contribution in helping the group meet its purposes?

6. What kinds of help do you think you need to become a more efficient member of the group?

ERIC Clearinghouse
APR 27 1970
on Adult Education